CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/30/2011 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155758			LDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 02/10/2011	
	PROVIDER OR SUPPLIER	MENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR STREET GREENCASTLE, IN46135				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F0000	This visit was for Complaint IN000	r the Investigation of 085414.	F00	000			
	federal/state defi	085414 - Substantiated, ciencies related to the ted at F329 and F502.					
	Survey date: Fel	bruary 10, 2011					
	Facility number: 001120 Provider number: 155758 AIM number: 200525120 Survey team: Joyce Hofmann, RN Census bed type: SNF: 22 SNF/NF: 23 Residential: 52 Total: 97 Census payor type: Medicare: 7 Medicaid: 16 Other: 74 Total: 97						
	Sample: 4						
	1	also reflect state findings ith 410 IAC 16.2.					
	Quality review com	pleted 2/15/11 by Jennie					
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: N0CT11 Facility ID: 001120

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155758		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 02/10/2011			
ASBURY		MENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR STREET GREENCASTLE, IN46135					
ASBURY (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)			LD BE	(X5) COMPLETION DATE		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155758	B. WIN	G		02/10/2011
	VIDER OR SUPPLIER DWERS RETIREN	MENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR STREET GREENCASTLE, IN46135			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
SS=D refit the bound of the bou	eview, the factor resident's land lood coagulated recommendations for eviewed in a set of the Assistant I ADoN] was inticated Resident and located Resident eviewable, and been sent the ruising on her the Resident #C's deviewed on 02 and indicated to the resident eviewed on 02 and indicated to the recommendation of the Resident #C's deviewed on 02 and indicated to the ruising on her recommendation of the Resident #C's deviewed on 02 and indicated to the ruising on the recommendation of the ruising on her ruising on her ruising on her ruising on the recommendation of the ruising on her ruising on the ruising of the	de: Director of Nursing nterviewed during he Health Care Unit 11:10 a.m. and dent #C was independent, and to the hospital for	F03	29	F 329 483.25 (I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGSEach resident's drug regimen must free from unnecessary drugs. Unnecessary drug is any drug when used in excessive dose; for excessive duration; or with adequate monitoring; or without adequate indications for its ustor in the presence of adverse consequences which indicate dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment or resident, the facility must ensuthat residents who have not us antipsychotic drugs are not given these drugs unless antipsychotic drugs are not given these drugs unless antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs and original requisition for the PT/INR that was being sought the State surveyor. On 02/14, the Director of Nursing creases new monitoring log book All licensed nurses have been	be An gor out ut ut ut; the factor sed ven otic reat sed ven otic

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N0CT11

Facility ID:

001120

If continuation sheet

Page 3 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		
		155758	B. WIN			02/10/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
∆CRI ID∨	TOWERS RETIDE	MENT COMMUNITY		1	POPLAR STREET NCASTLE, IN46135	
				<u>.</u>	10A31LL, 11140133	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	and had diagno	oses which included,			in-serviced on the new proced	
	but were not li				and use of the forms contained	
		ifarction, elevated			the binder. The in-service was held 02/14/1102/1811 as a or	
	_				on one dicussion between each	
	troponin, hype				nurse and the Director of	
		a, degenerative joint			Nursing. The binders have be placed on each unit and the	en
	disease, status	-			procedure will be implemented	d on
	carcinoma, his	tory of pneumonia,			02/18/11. Each nurse is to gla	ince
	history of cong	gestive heart failure,			at the log upon coming on duty make certain that labs ordered	
	history of left	leg cellulitis, left			that day have been signed off	
	knee replacem	ent, 2009, right hip			being completed, and if not, to	
	replacement 20				investigate the reason why the	ey
	•	boli, constipation,			have not been done. The Director of Nursing will observe	e
	•	* *			each book on a weekly basis a	I
	hypercholester				second check to ensure the	
		eal reflux disorder,			charge nurses are getting the log completed accurately.	lab
	,	chronic obstructive			Monitoring will be ongoing.	
	pulmonary dis	ease.				
	Dagidant #Cla	ulaus iu diasta da				
		care plans indicated a				
	_	d 01/06/11 for the				
		k for ecchymosis				
	secondary to a	nticoagulant therapy				
	and had a goal	of "Resident will not				
	have ecchymos	sis larger than 12.5				
		NR [till next review]."				
		ncluded, but were				
		"Medications and				
	labs as MD or					
	1008 08 11110 010	uciōu.				
FORM CMS-2	567(02-99) Previous Version	ns Obsolete Event ID:	 N0CT11	Facility 1	ID: 001120 If continuation sl	heet Page 4 of 18

PRINTED: 03/30/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155758		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 02/10/2011	
	PROVIDER OR SUPPLIER	MENT COMMUNITY	STREET.	ADDRESS, CITY, STATE, ZIP CODE POPLAR STREET NCASTLE, IN46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
TAG	The Physician January 2011 is had an order for anti-coagulan Lovenox [anti-[subcutaneous Coumadin [and daily, among of the company of the com	Is Orders dated indicated Resident #C for Aspirin t] 81 mg every a.m., coagulant] 1 mg sq anti-coagulant] 5 mg other medications. Nurses Notes dated a.m. indicated the lained of abdominal ea. Tylenol was given pain and an the abdomen was ag was noted on the eth measured 13 cm x rple/blue in color x 4.5 cm dark red hard/knot in the ft side measured a 5 Illow/green bruise. noted an late entry for a call placed to eto labs of a PT/INR I not drawn which	TAG			DATE

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155758	B. WIN			02/10/2	011	
	PROVIDER OR SUPPLIER	MENT COMMUNITY	•	102 W F	DDRESS, CITY, STATE, ZIP CODE POPLAR STREET CASTLE, IN46135	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
	doctor was not via phone at 7 and a stat [imrordered and the and the lab was and the lab was the nurse's not 01/15/11 indiction of the highest pailight pain. The cm x 5.5 cm as was paged. Laback yet. At 9 doctor gave not Resident #C to for evaluation abdominal pair resident was so was notified. The lab results indicated a Pro 17.7 which was	tes at 9:30 a.m. on ated the resident pain of a score of 9 to 10 with 10 being in level and 1 very e knot measured 3.5 and the medical doctor ab results were not 0:45 a.m., the medical ew orders to send the emergency room and treatment of an and bruising. The ent out and the family						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155758	A. BUI B. WIN	LDING IG		02/10/2	011
	PROVIDER OR SUPPLIER	MENT COMMUNITY	•	102 W F	ADDRESS, CITY, STATE, ZIP CODE POPLAR STREET ICASTLE, IN46135		
	SUMMARY S (EACH DEFICIENCE REGULATORY OR 1.8 which was range was 0.9 Notes at 11:55 resident return emergency root discontinue that a heating pad to needed. The fill reduce the medication Action (MAR) indicate order for the P transcribed on date for the lab completed was 01/12/11. No date marked for indicated blood had been obtain the Physician dated 01/10/11	MENT COMMUNITY TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) high [as reference - 1.1]. a.m. indicated the ed from the om with new orders to e Lovenox and to use to abdomen as family was notified. January 2011 Iministration Record ted the physician's T/INR had been to the MAR, and a o work to be as indicated on nurse's initials on the or the lab work d for the lab work	B. WIN	STREET A	POPLAR STREET	1	(XS) COMPLETION DATE
	` ′	R on Wednesday [name of physician's lity]					

001120

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S COMPL		
		155758	B. WIN	NG		02/10/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE POPLAR STREET		
ASBURY	TOWERS RETIRE	MENT COMMUNITY		1	CASTLE, IN46135		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	(2) fasting lipid panel with 1/12						
	PT/INR draw	"					
	Interview with	the Director of					
		on 02/10/11 at 1:15					
	p.m. indicated	-					
	· ·	sheet is filled out and					
	_	nen the lab person					
	~	eets out of the box					
	_	ne in to draw the labs.					
		cated the order for the					
	MAR.	raw was put on the					
	1111 111,						
	Interview with	the DoN on					
	02/10/11 at 2:0	00 p.m. indicated she					
		lab facility and the					
		ve a copy of the lab					
	requisition she	eet.					
	Interview with	the ADoN on					
		40 p.m. when she					
		ne missed lab draw,					
	_	er [ADoN] that the					
	lab person cou	ld not find the					
		[name of another					
	* =	lab person had her					
	listed as a resid	dent at the [name of					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155758		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/10/2011		
	PROVIDER OR SUPPLIER	MENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR STREET GREENCASTLE, IN46135					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	other facility] Towers.	instead of Asbury						
	supervisor stardocumented of Resident #C will lab draw and the being at anoth at the resident. The notes indiffered fax confirmation received the fax confirmation received the fax sury Tower Review of a with the DoN dated the following: of ADoN] that out [name of I drawn on 1/11 lab drawer said unavailable for She was not lid "draw sheet" the lab listing test for the day	ted the lab had in 01/12/11 that was unavailable for the they had her down as er facility instead of the discrete the facility had on that laboratory acility's fax which had its name and address. The statement by 1/10/11 indicated "I was told by [name at she called lab to find Resident #C] was not 1/11. She stated that it directed that we receive from who is due for what y. The nurse in the old me that the lab						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155758			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/10/2011	
	PROVIDER OR SUPPLIER	MENT COMMUNITY	1	STREET A	DDRESS, CITY, STATE, ZIP CODE POPLAR STREET CASTLE, IN46135	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
TAG	girl takes the relab box at the month and take through our she few from Dec and Jan 11 [Jan one for _[name called lab and representative "never rec'd [reat least it is no computer system for 01/15/2011]. The day nurse Care Unit individuals which is faxed facility's name and is filled out the resident's redate, date of be security number physician's name faxed to the lab faxes the fawith the residents.	equisitions out of the beginning of the es them. I looked red box and found a 10 [December 2010] muary 2011] but not e of Resident #C]. I spoke to a who reported they eccived] the order or t found in their em" only the PT/INR was in the system." RN#1, for Health cated the lab sheet to the lab has the and address on it it by the nurse with name, room number, irth, sex, social er, and the me. This sheet if b, then in return the accility back a sheet		TAG			DATE
	on a certain da	te. After the lab					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155758			ľ	MULTIPLE COI JILDING NG	NSTRUCTION	COMPI 02/10/2	LETED	
	PROVIDER OR SUPPLIER	MENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR STREET GREENCASTLE, IN46135					
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	signed by the person and the notebook. RN							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155758	B. WING			02/10/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	-		102 W	POPLAR STREET		
		MENT COMMUNITY			NCASTLE, IN46135		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG			Fos				DATE
F0502		ew and record review, the	F05	02	F 502 SS=D483.75(j)(1) PROVIDE/OBTAIN		02/18/2011
SS=D	<u>-</u>	ensure their laboratory			LABORATORY		
		d physician's orders for			SVC-QUALITY/TIMELYThe		
		ordered for 1 of 3			facility must provide or obtain		
	residents reviewe	ed in a sample of 4 for			laboratory services to meet the		
	PT/INR [Protime	e/International Ratio]			needs of its residents. The faction is responsible for the quality at	-	
	testing [This is a	test used to evaluate the			timeliness of the services.No	iiu	
	effect of adminis	tration of anticoagulant			residents were harmed by this		
	drugs]. Resident	: #C			deficient practice.On 02/14/11	,	
					after searching through some		
	Findings include	:			files in my office, I was able to locate the fax confirmation and		
	S				original requisition for the PT/I		
	The Assistant Di	rector of Nursing			that was being sought by the	I VI V	
		erviewed during initial			State surveyor. The Director of	of	
		h Care Unit on 02/10/11			Nursing spoke with Gina		
		l indicated Resident #C			Downings, the Medlab custom		
					service representative, regardiction concerns with the lab process.	-	
		e, independent, and had			On 02/14/11 a new monitoring		
		nospital for bruising on			book was created and all licen	-	
	her abdomen.				nurses have been in-serviced		
					the new procedure and use of	the	
	Resident #C's cli				forms contained in the binder.	/44	
		0/11 at 11:40 a.m. and			The in-service was held 02/14. -02/18/11 as a one on one	/ 11-	
	indicated the resi	dent was admitted to the			discussion between each nurs	e	
	facility on 01/06/	11 and had diagnoses			and the Director of Nursing. T		
	which included, l	but were not limited to,			binders were placed on each ι		
	left hemispheric	infarction, elevated			with their implementation to sta	art	
	troponin, hyperte	ension, hyperlipidemia,			on 02/18/11. Each nurse was instructed to glance at the log		
	degenerative join	nt disease, status post			upon coming on duty to make		
	renal cell carcino				certain that labs ordered for th	at	
		pneumonia, history of congestive heart			day have been signed off as		
	failure, history of left leg cellulitis, left				being completed, and if not, to		
	knee replacement, 2009, right hip			investigate the reasoning. The Director of Nursing will monito			
replacement 2007, history of pulmonary			the log books on a weekly bas				
		· ,				-	
			1				

II .		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155758		LDING	NSTRUCTION	(X3) DATE S COMPL 02/10/2	ETED
NAME OF PROVIDER OR SUPPLIER			-!	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
ASBURY TOWERS RETIREMENT COMMUNITY				1	ICASTLE, IN46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	emboli, constipation, hypercholesterolemia, gastroesophageal reflux disorder, and history of chronic obstructive pulmonary disease.				as a second check to ensure to charge nurses are getting the log book completed accurately Monitoring will be ongoing.	lab	
	plan dated 01/06 risk for ecchymo anticoagulant the "Resident will no than 12.5 centime review]." Interv	erapy and had a goal of ot have ecchymosis larger eters TNR [till next entions included, but to, "Medications and labs					
	2011 indicated R for Aspirin [anti- a.m., Lovenox [a [subcutaneous] 6	Orders dated January desident #C had an order coagulant] 81 mg every anti-coagulant] 1 mg sq every 12 hours, and ati-coagulant] 5 mg daily, dications.					
	01/10/11 indicate following: " (1) PT/INR call to [name of facility]	elephone Orders dated ed orders for the on Wednesday 1/12 & physician's healthcare panel with 1/12 PT/INR					
	Review of the Ja	nuary 2011 Medication					

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155758		B. WING			02/10/2011		
					ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF PROVIDER OR SUPPLIER				102 W F	POPLAR STREET		
ASBURY TOWERS RETIREMENT COMMUNITY				<u>.</u>	ICASTLE, IN46135		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY	•	DATE
	Administration Record [MAR] indicated						
		rder for the PT/INR had					
	been transcribed	onto the MAR, and a					
	date for the lab w	vork to be completed was					
	indicated on 01/1	12/11. No nurse's initials					
	on the date mark	ed for the lab work					
	indicated blood f	For the lab work had been					
	obtained.						
	Daily Skilled Nu	rses Notes dated					
	01/15/11 at 6 a.m	n. indicated the resident					
	complained of abdominal pain and nausea. Tylenol was given for abdominal pain and an assessment of the abdomen was made. Bruising was noted on the						
		measured 13 cm x 31 cm					
	-	in color with a 3.5 cm x					
		area that was hard/knot in					
		eft side measured a 5 cm					
		lue/yellow/green bruise.					
		ted an late entry for 3:20					
	_	aced to laboratory due to					
		and lipid panel not					
	drawn which were due on 01/12/11.						
	The notes indica	ted the medical doctor					
	was notified the the issues via phone at 7:45 a.m. on 01/15/11 and a stat [immediate] PT/INR was ordered and the						
	*	and the lab was drawn.					
	The nurse's notes	s at 9:30 a.m. on 01/15/11					
	indicated the resi	ident complained of pain					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
	155758		B. WING			02/10/2011	
NAME OF PROVIDER OR SUPPLIER			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF TROVIDER OR SOFTEIER				1	POPLAR STREET		
ASBURY	TOWERS RETIRE	MENT COMMUNITY		GREEN	NCASTLE, IN46135		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT PROFILE (FACH CORRECTIVE ACTION SHOUL		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE	
	of a score of 9 on a scale of 1 to 10 with						
	-	nest pain level and 1 very					
		anot measured 3.5 cm x					
		nedical doctor was paged.					
		not back yet. At 9:45					
		doctor gave new orders					
		#C to the emergency					
		ion and treatment of					
	_	and bruising. The					
		t out and the family was					
	notified.						
	TI 11 1 C	01/17/11: 1: 1					
		or 01/15/11 indicated a					
		ne of 17.7 which was high					
	-	ge was 9.1-11.1] and an					
		n was high [as reference					
	range was 0.9 - 1	1].					
ı	Notes at 11:55 a	m. indicated the resident					
		e emergency room with					
		scontinue the Lovenox					
ı							
		ing pad to abdomen as					
	needed. The fam	my was nouncd.					
	 Interview with th	ne Director of Nursing					
	Interview with the Director of Nursing [DoN] on 02/10/11 at 1:15 p.m. indicated when labs are ordered, a lab sheet is filled out and put in a box, then the lab person gets the lab sheets out of the box when they come in to draw the labs. The DoN indicated the order for the 01/12/11 lab draw was put on the MAR.						
	uiaw was put on	uic MAN.					

PRINTED: 03/30/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155758	B. WING			02/10/2011	
NAME OF PROVIDER OR SUPPLIER			 	1	ADDRESS, CITY, STATE, ZIP CODE POPLAR STREET		
		MENT COMMUNITY			ICASTLE, IN46135		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	PPROPRIATE DATE	
	Interview with the DoN on 02/10/11 at						
		ed she had called the lab					
	facility and the la	ab did not have a copy of					
	the lab requisition	n sheet.					
ı	Interview with th	ne ADoN on 02/10/11 at					
		she investigated the					
	missed lab draw,	_					
	· ·	lab person could not find					
	the resident at the	e [name of another					
	facility] as the lab person had her listed as a resident at the [name of other facility] instead of Asbury Towers.						
	The ADoN's note	es indicated the lab					
		the lab had documented					
	on 01/12/11 that	Resident #C was					
	unavailable for th	ne lab draw and they had					
	her down as bein	g at another facility					
	instead of at the	resident's current					
		tes indicated the facility					
		tion that laboratory					
		lity's fax which had					
	Asbury Towers n	ame and address.					
	Review of a writ	ten statement by the DoN					
	dated 02/10/11 ir	ndicated the following: "I					
	-	ne of ADoN] that she					
		out why [name of					
	I -	s not drawn on 1/11/11.					
		b drawer said resident					
		for draw that morning.					
	She was not liste	d on the printed "draw					

001120

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155758		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		B. WING			02/10/2011		
NAME OF PROVIDER OR SUPPLIER ASBURY TOWERS RETIREMENT COMMUNITY				STREET A	ADDRESS, CITY, STATE, ZIP CODE POPLAR STREET ICASTLE, IN46135		
ASBURY (X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) sheet" that we receive from the lab listing who is due for what test for the day. The nurse in the health center told me that the lab girl takes the requisitions out of the lab box at the beginning of the month and takes them. I looked through our shred box and found a few from Dec 10 [December 2010] and Jan.11 [January 2011] but not one for [name of Resident #C]. I called lab and spoke to a representative who reported they "never rec'd [received] the order or at least it is not found in their computer system" only			1		ΤΕ	(X5) COMPLETION DATE
	the PT/INR for 0 system." On 02/10/11 at 4 RN#1, for health lab sheet which i facility's name ar filled out by the name, room num sex, social securi physician's name the lab, then in refacility back a sh name and inform drawn on a certain person draws the by the nurse and sheet goes into a	1/15/2011 was in the 1/15/2011 was in the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155758		(X2) MULTIPLE CC A. BUILDING B. WING		COMP	(X3) DATE SURVEY COMPLETED 02/10/2011			
NAME OF PROVIDER OR SUPPLIER ASBURY TOWERS RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 102 W POPLAR STREET GREENCASTLE, IN46135					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	ILD BE	(X5) COMPLETION DATE		
	This federal tag in IN00085414. 3.1-49(a)	is related to Complaint						